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presented by the author

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CASE I—*Gumma of the iris; secondary cataract; preliminary iridectomy followed by extraction; glaucoma; recovery with excellent vision.*—Robert Kingsberry was admitted to the Ophthalmic Wards of the Philadelphia Hospital on the 28th of December, 1891, presenting the following symptoms: In the right eye the cornea was hazy, and a large yellowish-white mass, not crossed by vessels, which pushed its way towards the ciliary border, partially filled the anterior chamber, at the bottom of which a layer of pus had collected. The other eye was similarly affected, the deposit growing from the iris having a whitish rather than a yellowish-white appearance, and also a tendency to spread toward the ciliary region. There were violent photophobia, chemotic conjunctiva and swollen lids.

Shortly after admission, the patient exhibited a curious type of delirium, characterized by a fixed delusion of persecution, terminating in an irregular type of delirium tremens. The mental condition of the patient was such that an exact clinical history was not obtained, nor was the date of syphilitic infection, which, however, was undoubted, accurately determined. It probably occurred about two years before the gummata appeared in the iris.

After the usual treatment for such condition, the violence of the inflammation gradually subsided, the eyes became quiet, but the irides were atrophic and well-marked scars were visible at the spots formerly occupied by the gummatous deposits, both pupillary spaces being partially occluded.

He remained in the Hospital for some time, and then disappeared, returning again in the fall of 1892. When he was examined, November 1, 1892, the pupil of the right eye was irregular, partly occluded with lymph and iris pigment, a broad scar being visible in the iris to the nasal side; ophthalmoscopic examination was impossible. Vision equalled counting fingers at one foot.

In the left eye there was a similarly scarred iris, a somewhat larger pupil, behind which a white cataract was visible. The light perception was good in all parts of the field.

About two weeks before, namely, on the 16th and 20th of October, my colleague, Dr. Gould, had made two discissions, without, however, causing perceptible absorption of the cataractous lens. Dr. Gould very kindly referred the case to me when I came on duty, the first of November, for further operative interference. As two well-considered and carefully performed discissions had been practically without effect, it was deemed advisable that a formal extraction should be undertaken. On the 7th of November I performed a small, upward iridectomy, obtaining a clear coloboma, save a slight irregularity at the lower margin, marking the position where the iris had been attached to the capsule of the lens. The healing was perfectly smooth, and on the 28th of the same month, the lens was extracted without difficulty, except that the capsule was found exceedingly tough. No accident occurred during the healing, and on the fifth day after the operation the bandages were removed and the patient allowed the liberty of the ward, with the protection of a shade.

On the 13th of December the patient began to complain of pain in the eye, which became watery, and a small spot of infiltration appeared in the lower margin of the cornea. Atropine was instilled for one day at intervals of four hours, but on the following day he was found in a pitiable plight, complaining of intense pain through the entire left side of the head. The lids were œdematous, the conjunctiva slightly chemotic, the cornea hazy throughout its entire surface, and the T. + 2. Vision amounted to faint light perception.

He was freely leeches from the temple; eserine drops, one-half grain to the ounce, together with a 2 per cent solution of cocaine were instilled into the eye every two hours, and full doses of chloral and small doses of morphia were administered at bed-time. The following day he was better, but two days later he had a relapse. The house surgeons, Dr. Montegut and Dr. Marcus, repeated the leeching and increased the number of instillations of the eserine and cocaine solution. In addition to the hypnotics at night, mercurial inunctions were ordered, two drachms being rubbed into the skin of the abdomen during each twenty-four hours. By the end of the month he was vastly improved and could readily tell the time of day on a watch. After this his recovery was uninterrupted. The eye became white and quiet, the cornea transparent, the colo-

boma only slightly obstructed by a few strands of capsule, and the vitreous perfectly clear. The disc is a vertical oval of good color, and no splotches are visible in the fundus. In February of the present year his vision, with + 12. spherical, is $\frac{6}{12}$ and part of $\frac{6}{8}$, and with + 16. s. he reads Jäger I, quite readily.

Remarks.—This case seems worthy of record on account of the somewhat remarkable series of diseases, as well as surgical events, experienced by this patient. The gummatous irido-cyclitis was followed, as an almost necessary consequence, by secondary cataract, and the extraction of this without accident was of itself a gratifying feature. The development of a series of symptoms, which may with propriety be designated as glaucoma after extraction, are not so readily explained. There is, however, a slight entanglement of the iris in the upper and inner part of the operation scar, and it is quite possible that the use of atropine for one day, when the symptoms first developed, was a piece of injudicious therapeutics, which determined the rapid rise of tension within a few hours and the violent pain which followed. The speedy relief of the condition under the influence of cocaine and eserine, aided by copious bloodletting, is interesting, and I cannot help thinking that the full doses of chloral, together with a rapid mercurialization were efficient aids in the happy result.

CASE II.—*Nuclear cataract; artificial ripening by direct trituration; extraction, followed by prolonged and at times violent dementia; recovery of reason and good vision.*

Diller Shirk, aged 59, a patient in the Ophthalmic Wards of the Philadelphia Hospital, had been suffering with cataract for about twenty months, in each eye, nuclear in character, very slow in development, and most marked upon the left side. In addition to his visual defects, he had organic heart disease, with loud, double murmurs over the aortic cartilage, and almost constant, and at times serious cardiac vertigo. The urine contained albumin and casts. He was greatly depressed by his general condition, but especially by his inability to read.

As the growth of the cataract was so slow, on the 14th of November, 1892, a preliminary iridectomy was performed and the capsule of the lens triturated with a small horn spatula. Advance of the cataractous process began at once, and by the 16th of December the lens was of a thick white color in its entirety. On the 30th it was extracted through a 3 millimeter flap, resulting in a perfectly black pupil and the ready counting of fingers.

For two days the patient was in perfectly good condition, but on

the night of the third day after the operation he became delirious, got out of bed, struck his eye, burst open the wound, causing a blood-clot which half filled the anterior chamber. He now passed into a state of dementia, often of a violent character, necessitating constant watching. Emancipation became marked; there was involuntary passage of urine and feces; liquid food was administered with difficulty; the pulse was exceedingly feeble and irregular; some hypostatic congestion of both bases of his lungs became evident, and thick sordes formed on the teeth and tongue.

The treatment consisted of free stimulation with whiskey, condensed and for the most part liquid nourishment, and full doses of strychnia and digitalis. The drugs, however, appeared to have no influence upon the circulation, and consequently the resident surgeon, Dr. Montegut, began the administration of nitroglycerine, pushing it to its full physiological effect. Very soon improvement began, and by the last week in January he had recovered sufficiently to sit up for a few hours of the time, although he was still somewhat demented and required watching. This improvement has continued, and at the present writing, February 20, his mental derangement has largely disappeared, he eats solid food with avidity, his nutrition has improved, and in all respects he has practically recovered. Curiously enough, during the whole of this time there was no unfavorable symptom in the eye. The blood-clot caused by the blow was speedily absorbed, and save some slight conjunctival redness which lasted for a few days, there was no reaction. The coloboma is clear, the eyeground healthy, and the vision with his glasses equals $\frac{6}{30}$, and he reads hesitatingly 0.75 type.

Remarks.—This is a very good example of the cases which have been denominated “insanity after operations,” and of which there are a number upon record. The occurrence of such phenomena after operations in general, and especially gynecological operations, has been noted many times, and also, but less frequently, after extraction of cataract. It seems likely that mania or dementia, is most apt to occur in an individual whose mental balance is not entirely secure before the operation, and in the case which has been described, the patient's anxiety, both on account of his cardiac and ocular conditions, culminated after the extraction in the symptoms which have been described—an anxiety which had long been nursed by previous misfortune, inasmuch as his wife had been insane, and during one of her paroxysms had committed suicide. Of course this condition is entirely distinct from the

traumatic delirium which sometimes succeeds an excessive reaction after injury or operation, and is most common, I think, in those patients who have indulged in alcoholic excesses.

CASE III.—*Large pterygium and moderate symblepharon following a lime-burn; removal and successful transplantation of a Thiersch's skin graft upon the bulbar conjunctiva (Hotz's operation).*

Albert Block, aged 22, an inmate of the Ophthalmic Wards of the Philadelphia Hospital, sustained a lime-burn of the right eye two years ago. This resulted in the formation of a large, fan-shaped, fleshy pterygium, which extended in the usual position from the plica, and was attached as far as the centre of the cornea, occupying its lower and inner quadrant. From this the fibres extended to the lower lid, binding its inner surface to the bulbar conjunctiva in a mass of cicatricial tissue 8 millimeters in length, passing outward from near the inner angle, but not quite up to the ciliary margin. (Vide Fig. I.)

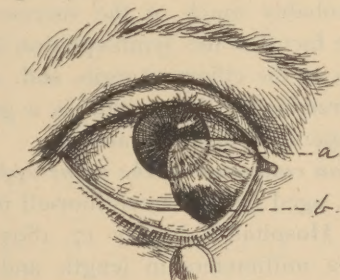


FIG. I.

Pterygium and symblepharon: a, fleshy pterygium; b, portion attached to lower lid, forming a small symblepharon.

On the 7th of November, 1892, the entire mass was carefully dissected away, leaving a large, bared area on the globe and inner surface of the lid. A Thiersch's skin graft was then carefully cut from the inner side of the forearm of the patient, with which the gap was covered according to the directions given by Hotz (Transactions of the Ophthalmological Section of the American Medical Association, Detroit, 1892, p. 185). This graft was 2 centimeters in length and nearly a centimeter in breadth. A smaller graft was placed deep down in the sulcus. The eye was bandaged antiseptically and undisturbed for forty-eight hours.

At the end of this time the graft lying on the bulbar conjunctiva was firmly attached; that in the sulcus, however, had rolled up and had to be trimmed away in great part. For a long time there

was a good deal of accumulation of a whitish secretion in the corner of the eye, partly mucus and partly epidermal cells. The eyeball is now movable in all directions. The graft still remains white and can be distinctly seen in its position, having shrunk to a size 8 by 14 millimeters. It has accomplished in a most satisfactory way the purpose for which it was planted. The eye, which had previously been irritable, became quiet, and although the haze in the cornea forbids accurate vision, this has distinctly improved, fingers being counted readily in all directions, while previously only the motion of the hand was discerned excentrically. From a cosmetic standpoint there is little to be desired.

Remarks.—Dr. Hotz's valuable suggestion to employ Thiersch's skin grafts after the removal of large pterygia found ready application in the present case. Not only did the graft supply the deficiency caused by the removal of an ungainly and unusually large pterygium, but it also prevented the re-attachment of the symblepharon. It should be stated, so far as the last-named defect is concerned, that probably much of the success of the operation depended upon the fact that the symblepharon did not bind down the lid entirely up to the ciliary margin, and, as is well known, even the smallest freedom of this margin is a great gain in securing success in an operation of this character.

CASE IV.—*Cornu cutaneum of the right upper eyelid.*

Edward Connor, aged 40, presented himself for treatment in the Jefferson College Hospital, February 17, 1893, on account of a cutaneous horn, 12 millimeters in length and 4 millimeters in thickness, which grew from the ciliary border of the right upper eyelid near the outer commissure. (Vide Fig. II.)

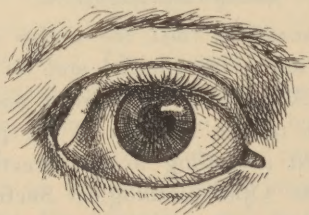


FIG. II.

Cornu-cutaneum, twelve millimeters in length and four millimeters in diameter.

The growth had first made its appearance about two years ago, and, according to his statement, had been removed three times, with recurrence on each occasion. The present growth had been developing five or six months. It was entirely painless, of a yellowish-red color, and of the general consistence of thickened epidermis, the

somewhat conical end being capped with a few horny scales. The horn was excised and the portion of the lid from which it grew thoroughly cauterized with chloride of zinc.

Remarks.—This cutaneous horn has followed the rule of similar excrescences in that it appeared in a patient of middle life and was unattended by pain. In spite of its recurrence there was nothing on the lid or at its base suggestive of epithelioma, and there is no reason to doubt that the microscope will show that it is composed of a hyperplastic growth of the mucous layer of the epidermis.

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